

**UTAH PHARMACY COST CONTAINMENT INITIATIVES
COMPARED TO
THE KAISER COST CONTAINMENT STRATEGIES FOR PRESCRIPTION DRUGS**

The Kaiser Family Foundation published the Cost Containment Strategies for Prescription Drugs. Each initiative is listed below and compared to the initiatives adopted by the Utah Medicaid Program. As can be seen by the comparison, Utah has already adopted those initiatives which are applicable to the Medicaid program. This summary has been updated to reflect the current status of the Medicaid Program as of 7/11/2007. (*Utah Initiatives and responses are in italics.*)

1. Utilization Strategies

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Exclusion of specific drugs or drug classes from coverage	X		(1) Medicaid currently excludes some classes for drugs: weight loss, weight gain, hair restoration products, vitamins and mineral except for children and pregnant women, (2) Kids get any drug that is medically necessary, (3) Drug rebates are contingent on coverage of the drugs	
b. Exclusion of over-the-counter drugs from coverage,	X		Selected coverage of Over-the-counter drugs. Exclusion of all over-the- counter drugs can generate prescriptions for alternative brand name drugs.	
c. Dispensing limits (quantity limits) for a particular drug or prescription	X		(1) Medicaid has quantity limits and early refill limits, (2) Medicaid does not limit the number of prescriptions a client receives. This would place a large burden on nursing home clients who receive multiple scripts per month. See 1 (d) below.	\$862,200
d. General limits or caps on the quantity of prescriptions covered		X	Medicaid does not have an overall cap on the number of scripts or drugs.	

e. Concurrent (prospective) drug utilization review	<input checked="" type="checkbox"/>	Medicaid has a prospective drug utilization review program. This is a "real-time" Point of sale system. This computer system makes payments in an efficient manner while at the same time checking for multiple adverse drug events for all prescriptions. This system helps avoid unnecessary hospital stays.	\$1,172,600
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2. Utilization Management Approaches

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Prior Authorization Requirements	<input checked="" type="checkbox"/>		Utah has a Prior authorization Program. It is our most effective management tool currently in place. Our current response rate is within 15 minutes. We are required by Federal Law to respond to all requests within 24 hours and still allow for payment of emergency prescriptions for up to a 3 day supply. It is frequently combined with selected step therapy and therapy specific fail first policies.	\$3,632,200
b. Step therapy or fail-first requirements	<input checked="" type="checkbox"/>		Please see 2(a) above. Not to be confused with therapeutic substitution or therapeutic intervention programs.	
c. Therapeutic substitution or therapeutic intervention			X Unlike generic substitution, therapeutic substitution or therapeutic intervention is a program that switches a patient from one medication to another that is in the same therapeutic class. Any such activity requires the explicit consent of the prescribing physician and by law cannot happen without it. A mandatory program is not an option.	
d. Closed formulary		<input checked="" type="checkbox"/>	Although in use in the private sector, Utah Medicaid is prohibited by statute from having a closed formulary.	
e. Preferred drug list; open formulary			Utah has an open formulary. Preferred drug lists have long been a tool of private insurers and other States. A PDL lacking the usual components of a preferred drug list (most notably a Prior Authorization tool) has recently been authorized. Legislative intent associated with S.B. 42, has recently limited cost saving strategies	

			<p>associated with Prior Authorizations and limited our ability to use it. A PDL is a tool designed to influence market share for cost effective preferred agents within a drug class or category. Utah Medicaid is one of the very last States to implement a preferred drug list.</p>	
f.	Mandatory generic substitution	X	Utah Medicaid requires generic substitution.	\$3,146,000
g.	Management of Specialty drugs	X	Utah has a prior authorization program for drugs which are relatively low usage but high cost. Orphan drugs, biologicals, and some drugs administered in the physician's office are examples.	
h.	Provider financial incentives	X	<p>Utah does not have a program. Some providers have experimented with programs that offer financial incentives for meeting certain performance incentives. Insurers might offer financial incentives for increased use of generic drugs or for meeting certain target rates. This also includes requiring physicians to take capitation payments for the cost of drugs. No published studies have been identified that have examined the use of financial incentives for providers for meeting certain standards.</p>	
i.	Payments to pharmacies as incentives	X	This type of program has been used on a limited basis by PBMs who provide incentive payments to those pharmacies that meet standards for dispensing generic drugs, and/or dispensing preferred brand name drugs from a formulary. Another incentive could be paid when pharmacists offer additional counseling at the time of prescription pick-up. Actual achievements from this approach have been difficult to document. Utah does not have a program.	
j.	Other coverage management approaches: Tablet splitting / dose consolidation	X	One coverage management approach deals with pill splitting. A 100 milligram tablet is split into two 50 milligram pieces because the cost is less expensive than purchasing two 50 milligram tablets. Manufacturers oppose this practice on the grounds of dosing efficacy/safety. Medicaid is reviewing the possibilities of this program. At this time only about 20 drugs are suitable for splitting. Dose consolidation is the reverse.	
k.	Quantity limits	X	Utah Medicaid only allows a set number of doses in a thirty-day period. This prevents over use, and/or inappropriate use. This is specifically applied to narcotic pain meds.	

3. Cost sharing approaches

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Co-payments as a general strategy	X		Utah has adopted maximum co-payments from individuals who can be charged a co-pay.	\$1,601,600
b. Tiered co-payments in general	X		Federal Medicaid regulations impose limits on the amount and scope of co-payments. Since the Medicaid co-payments are very nominal, the effect of a tiered structure is questionable. Any tiering program would affect overall program savings. A tiered co-pay (no co-pay) program is being researched in connection with a PDL.	
c. Three-tiered co-payments	X		See 3 (b)	
d. Four-tiered or other more complex co-payment structures	X		See 3 (b)	
e. Co-insurance	X		Medicaid's co-payment for pharmacy already meets the maximum allowable charge for cost sharing of 5%. Because we charge a co-payment, we cannot charge co-insurance.	
f. Reference pricing	X		Reference pricing is a system that establishes a base price as a basis for reimbursement. Any amount charged above the reference price is the responsibility of the individual user of the drug. Medicaid regulations would not allow this type of cost sharing.	

4. General Utilization Review Strategies

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Retrospective drug utilization review	X		<i>The University of Utah College of Pharmacy provides a drug utilization review oversight function, including peer to peer consultation with physicians for clients that are high-end users</i>	\$1,086,800
b. Physician profiling	X		<i>In conjunction with its retrospective reviews, the College of Pharmacy consults with outlier physicians considered high-end users. The Behavioral Pharmacy Management System operated by Comprehensive NeuroScience (CNS) does the same with a focus on drugs used in behavioral pharmacy therapy.</i>	
c. Drug utilization review	X		<i>See 4(a), (b). Medicaid also has a client restriction program.</i>	
d. Disease management	X		<i>Disease management drug programs in Utah Medicaid have been limited to a contract with the University of Utah to manage hemophilia patients and to obtain their expensive clotting factor under 340(B) purchasing provisions. 340(B) prices are those given by statute to large government programs such as the VA system, and are considerably better prices than those generally obtained through the private sector. Other disease states that are potential candidates for disease management are: cystic fibrosis, diabetic therapy, asthma, pain management, and anticoagulation therapy.</i>	\$1,000,000
e. DUR Board	X		<i>The Drug Utilization Review Board is a federally and state mandated panel of medical professionals that advises the Division on Pharmaceutical related issues.</i>	\$657,800

5. Education Strategies

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Education of consumers and physicians on the benefits of generic drugs	X		Utah has a mandatory generic substitution policy See 2(f)	
b. Education of consumers and physicians on the appropriate use of particular drugs	X		The Behavioral Pharmacy Management program is a collaborative effort with Comprehensive NeuroScience, Inc., to identify prescribers of atypical antipsychotics who are “outliers”, meaning they hit specific indicators such as prescribing multiple drugs. The effort is focused on providing educational materials on best practices and, when indicated, peer consultations. Also see 4(b)	\$3,432,000
c. Counter detailing or academic detailing	X		Counter detailing, also known as academic detailing, refers to providing alternative information to that provided to physicians by the pharmaceutical manufacturers. In counter detailing, groups such as insurers or purchasers, or groups affiliated with them, can provide alternative messages. Due to a lack of resources, Utah Medicaid historically has not pursued this approach. However, Utah Medicaid has recently been awarded a Grant under the DRA Medicaid Transformation Grant program to develop a program that includes counter detailing. This will be collaborative effort with the U of U College of Medicine, the College of Pharmacy, and the VA.	
d. Development of unbiased information on the appropriate use of certain drugs	X		This approach is similar to counter detailing. Utah Medicaid will be using unbiased evidence based information in the development of its PDL.	

6. Pricing Strategies

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Use of purchasing pools, and	X		<i>Utah Medicaid is implementing a Preferred Drug List. An essential element to the success of a PDL includes securing secondary rebates and price advantages negotiated with manufacturers. These are conceded by manufacturers to the states because of favorable market shift resulting from PDL enforcement. The quality of the rebate is proportional to the strength of the enforcement tool. Utah has joined the Sovereign States Drug Consortium, a purchasing pool consisting of Vermont, Iowa, and Maine. Purchasing pools combine their respective prescription volumes to negotiate pricing concessions from manufacturers in the form of secondary rebates. However, Utah has been limited in its ability to enforce a PDL through legislative intent associated with S.B. 42, when the agency was told it could not use Prior Authorization as a management tool.</i>	
b. Additional rebates through market leverage				
c. Requirements to make prices and rebates transparent	X		<i>Among key components of an efficient market is complete information of product price. Since complete information on drug pricing is unavailable, the U.S. Market for prescription drugs generally fails to meet this market condition. This absence of price information limits the ability of purchasers to ensure that they are getting the best price for drugs. The Deficit Reduction Act of 2005 has provision for creating a new benchmark for drug pricing, the Average Manufacturers Price, or AMP. This new marker still relies upon manufacturer reporting to determine the price, and derives any further cost savings from pharmacy provider reimbursements. Increases in pharmacy provider dispensing fees may become an important issue.</i>	
d. Lower dispensing fees to the pharmacy - Lower cost of medication reimbursement.			<i>Utah's dispensing fees are in the middle to lower of fees paid by other States. Lowering current dispensing fees may have a negative impact on client access to medication.</i>	

	X	<p>Utah Medicaid has a Maximum Allowable Cost (MAC) program which Kaiser does not have. This program has a ceiling cost payment for select drugs as determined by a computer algorithm. This ensures lower drug costs.</p>	\$4,004,000
	X		

e. Maximum Allowable Cost (MAC)		
f. Use of restricted pharmacy networks	X	<p><i>Medicaid has a legal obligation to provide access to services. If client access could be maintained by establishing a network, there could possibly be an advantage to Medicaid. That advantage would have to be based on lower costs to Medicaid in exchange for greater volume for members of the restricted network. This approach would also require a waiver of the freedom of choice provision in federal regulations.</i></p>
g. Defined contribution approaches	X	<p><i>Under this approach, an employer contributes a fixed dollar amount toward health benefits and shifts the responsibility for those dollars to the employee. Usually, there is a defined contribution toward the cost of drugs. If that amount is exceeded, the consumer is responsible for the rest. This option is not available to Medicaid. .</i></p>

7. Lower Transaction Costs

DESCRIPTION	YES	NO	VARIANT – REMARKS	ANNUAL STATE FUNDS
a. Incentives for increased use of mail-order pharmacies	X		<p><i>Recipients can use mail-order if desired. Utah recognizes out-of-state and in-state mail order pharmacies. Again, restricting client use to mail order, even for selected drugs, would require a federal waiver, and further increase time to access for necessary medications.</i></p>	
b. Mandatory mail-order for maintenance medications	X		<p><i>See 7(a) above</i></p>	

c.	Importation of drugs	X	<p>While the transportation of personal quantities of drugs for personal use across international boundaries is generally ignored, the importation of drugs from pharmacies outside the U.S. is illegal. For Medicaid beneficiaries to take advantage of internet, mail-order pharmacies outside the U.S., would require those facilities to become Medicaid licensed providers. Since the State has no means to verify compliance with state licensing requirements, or pharmacy conditions, or source/quality of product, it is unlikely that the State would endorse a program that is illegal to begin with. Therefore, Medicaid beneficiaries would have to pay for their own drugs to take advantage of any foreign resource. States currently supporting importation are not providing to Medicaid beneficiaries. Federal participation funds are not available.</p>
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Summary of Strategies not in use or not available

- 1(d) General limits or caps on the quantity of prescriptions covered
- 2(c) Therapeutic substitution or therapeutic intervention
- 2(d) Closed formulary
- 2(h) Provider financial incentives
- 2(i) Payments to pharmacies as incentives
- 2(j) Other coverage management approaches: Tablet splitting/ dose consolidation
- 3(b) Tiered co-payments in general
- 3(c) Three-tiered co-payments
- 3(d) Four-tiered or other more complex co-payment structures
- 3(e) Co-insurance
- 3(f) Reference pricing
- 6(f) Use of restricted pharmacy networks
- 6(g) Defined contribution approaches
- 7(a) Incentives for increased use of mail-order pharmacies
- 7(b) Mandatory mail-order for maintenance medications
- 7(c) Importation of drugs

UTAH PHARMACY COST CONTAINMENT REGULATORY STRATEGIES AVAILABLE ONLY TO GOVERNMENT

The following strategies or actions could prove beneficial in slowing the increase in Medicaid drug costs. However, these initiatives would require either enactment of legislation or changes to current legislation.

1. Pricing Approaches

Description	Remarks
a. Expanded access to Medicaid rebates.	<i>Expanded access to rebates or changes to the rebate formula will only be effective if management by a full prior authorization program is allowed by the Utah legislature. Without management tools, secondary rebates will be limited because the rebate program will be viewed as a voluntary program which has limited effect on market share. In order for this to occur legislative intent will need to be clarified.</i>
b. Direct price regulation	<i>Unavailable to the state (Direct prices to pharmacies from suppliers)</i>
c. Expanded access to the federal supply schedule	<i>Unavailable to the state (VA purchasing)</i>

2. Direct Regulatory Approaches

a. Broader Availability of generic drugs	<i>This could only occur through changing patent protection laws</i>
b. Broader authority to move drugs to over-the-counter status	<i>This would require federal law changes</i>
c. Increased regulation of direct-to-consumer	<i>This would require federal law changes</i>

advertising.	
Reduced restrictions on importation of drugs from other countries.	<i>This would require federal law changes</i>